

APPLICATION FOR HOME MEDICAL DEVICE RETAILER EXEMPTEE LICENSE – NEW AND RENEWING

Date Received:	License Number:	Payment Type:	Amount: \$
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PLEASE DO NOT WRITE ABOVE THIS LINE**Read instructions on attached sheet. Unsigned or incomplete applications will not be processed.**
☐ **Renewal** ☐ **New Exemptee** ☐ **Transfer** ☐ **Additional License**

1. Name of Applicant:	Last	First	Middle	Former
Residence address:	Number and Street		City	State Zip Code
Home phone number: ()	Date of birth:	Social Security number:	If Renewal, Exemptee license No:	

2. Name of HMDR facility that exemptee will be working at:				
Address of HMDR facility:				
Number and Street		City	State	Zip Code
Work phone number: ()	HMDR license number of employer (leave blank if unknown):		Expiration date:	

3. Contact Name (if different from exemptee name):			
4. Mailing Address (if different from HMDR facility):		City	State Zip Code

5. Has the applicant ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," provide an explanation on a separate sheet.

6. Please provide the following information to determine if you meet the minimum qualifications (The following questions are for new applicants only).	
Do you have a high school diploma or equivalent? (<i>Attach a copy to the application</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold any of the following professional certifications or licenses (<i>Check all that apply & forward documentation</i>)	
Respiratory Therapist <input type="checkbox"/> LVN <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Pharmacy Technician <input type="checkbox"/> Other _____	
Have you had one year or more paid experience related to the distribution or dispensing of dangerous drugs or dangerous devices? (<i>Provide proof of 1 year experience</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you completed training program(s) that address the following:	
State and Federal laws relating to the distribution of dangerous drugs and dangerous devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
State and Federal laws relating to the distribution of controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The United States Pharmacopoeia standards relating to the safe storage and handling of drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The safe storage and handling of home medical devices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescription terminology, abbreviations, and format?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For all of the above questions answered <u>yes</u>, you must submit appropriate proof to verify qualifications.	

7. Certification of Exemptee - Please read carefully and sign below	
I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.	

Applicant Exemptee signature: (in full, no initials)	Date:
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THIS AREA IS TO BE COMPLETED BY THE EMPLOYER

8. Legal Name of Home Medical Device Retailer:	HMDR license number:			
Business name: (if different)				
Address of Home Medical Device Retailer:				
9. The applicant medical device retailer will sell the following products: (<i>Check all that apply</i>) <table style="width: 100%; border: none;"><tr><td style="width: 33%; vertical-align: top;"><input type="checkbox"/> Respiratory Equipment / O2 Supplies <input type="checkbox"/> CPAPS, BiPAPS <input type="checkbox"/> TENS Units <input type="checkbox"/> Infusion Pumps <input type="checkbox"/> Catheters <input type="checkbox"/> CPM Machines</td><td style="width: 33%; vertical-align: top;"><input type="checkbox"/> Incontinence Supplies <input type="checkbox"/> Custom Wheelchairs <input type="checkbox"/> Power Wheelchairs <input type="checkbox"/> Manual Wheelchairs <input type="checkbox"/> Nutritional Supplements <input type="checkbox"/> Diabetic Test Supplies</td><td style="width: 33%; vertical-align: top;"><input type="checkbox"/> Walkers, Canes, Commodes <input type="checkbox"/> Hospital Beds / Mattresses <input type="checkbox"/> Other: Describe Below or attach list of products. _____ _____</td></tr></table>		<input type="checkbox"/> Respiratory Equipment / O2 Supplies <input type="checkbox"/> CPAPS, BiPAPS <input type="checkbox"/> TENS Units <input type="checkbox"/> Infusion Pumps <input type="checkbox"/> Catheters <input type="checkbox"/> CPM Machines	<input type="checkbox"/> Incontinence Supplies <input type="checkbox"/> Custom Wheelchairs <input type="checkbox"/> Power Wheelchairs <input type="checkbox"/> Manual Wheelchairs <input type="checkbox"/> Nutritional Supplements <input type="checkbox"/> Diabetic Test Supplies	<input type="checkbox"/> Walkers, Canes, Commodes <input type="checkbox"/> Hospital Beds / Mattresses <input type="checkbox"/> Other: Describe Below or attach list of products. _____ _____
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10. Does this Home Medical Device Retailer currently employ the person whose name appears on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No				
11. Will this person replace an Exemptee approved by the Department of Health Services? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Exemptee being replaced : _____ Exemptee Number: _____ _____				

12. Certification of Employer – Read carefully and sign below

I hereby certify that the application completed on this form is being presented to the Food and Drug Branch with my knowledge and approval. Also, it is my understanding that a person certified by the Food and Drug Branch must be on the premises and actively supervising operations at all times when prescription devices are being dispensed. I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in the foregoing application, including all supplementary statements.

Employer's signature:	Title:	Date:
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Home Medical Device Retailer Exemptee License Application Instructions

Please complete and/or amend this application as is most appropriate to your facility. Include the appropriate fee for each application as indicated in the fee schedule and make check payable to: CALIFORNIA DEPARTMENT OF HEALTH SERVICES. The application cannot be processed without the appropriate fees, complete documentation and appropriate signatures. Unsigned or incomplete applications cannot be processed and will be returned. Penalty for failure to renew the license within 30 days after expiration is an additional \$10.00 that must be added to the renewal fee before the license is issued. The following are further instructions on how to complete this application:

1. **Your Information:** Your name as it is to appear on the license issued by the Department of Health Services. *Residence address:* is the street address of where you actually live. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if you are located outside the California border. *Zip:* is the five-digit zip. If this is a renewal, enter your current Exemptee license number.
2. **Employer Information:** The legal name of the Home Medical Device retailer facility which you will be working at. *Address:* is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if the firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
3. **Contact Name:** Fill in the name of the person who will keep track of the Home Medical Device License and associated records and be responsible for applying for and renewal of this license.
4. **Mailing Address:** This address is where licensing information is to be sent if the address is a different location than the address of the location where business will take place.
5. **Felony:** Has the applicant ever been convicted of a felony? If "Yes," provide an explanation on a separate sheet.
6. **Minimum qualifications:** *Education:* High school diploma GED or equivalent. Attach copies of any applicable certifications or licenses that you may hold. *Work Experience:* One or more years paid experience, attach dates name(s) of employer(s) and addresses. *Training Programs:* Indicate by yes or no the training you have completed specific to the five topics listed. Attach copies of certificates or transcripts.
7. **Certification of Applicant:** After reading the instruction paragraph your signature is needed, please sign in full (no initials) and date.

Numbers 8 through 12 are to be completed by the employer.

8. **Firm Information:** The name of the Home Medical Device Retailer to appear on the license issued by the Department of Health Services. *HMDR license:* state current HMDR license number. *Corporate name:* Name of corporation if different from HMDR name. *Address:* is the street address of the firm where business will take place. *City:* is the municipality where the address is located. *State:* is normally California but change to another state if your firm is located outside the California border. *Zip:* is the five-digit zip code with 4-digit zip-plus for the location to be licensed.
9. **Type of products to be sold at this firm:** Check all appropriate boxes indicating types of products sold by this firm.
10. **Current Employment:** Check the appropriate box to verify employment.
11. **Replacement of approved Exemptee:** *Check box:* if applicant is replacing an approved Exemptee. *Name:* Exemptee being replaced. *Certificate number:* Exemptee being replaced certificate number.
12. **Certification of Employer:** After reading the instruction paragraph the employer's signature is needed, please sign, state title of signatory and date the signature. Mail the completed and signed application with the licensing fee (see table below) to:

Department of Health Services
Food and Drug Branch - Licensing
PO Box 997415, MS-1101
Sacramento, CA 95899-7415

License Category	Fee	Interval	New Application
Exemptee Application Fee	\$100.00	Once on application only (New Exemptee)	On application
Exemptee License Fee	\$150.00	Annually on renewal and 1 st license	On application

If you have any questions, please contact the Home Medical Device License Voice Mailbox at (916) 650-6518 and leave a message with your firm name, your name and your phone number and a staff member will return your call. You may also visit our internet web site at: <http://www.dhs.ca.gov/fdb/> for timely program news and a blank copy of this application form.